STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005268	A. BUILDING: _____ B. WING _____	C 09/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEBANON TERRACE	221 EAST THIRD STREET LEBANON, IL 62254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	COMMENTS Statement of Licensure Violations IRI of 08/12/15/IL79523 IRI of 08/12/15/IL79496	Z 000		
Z9999	FINDINGS 1of 2)Licensure Violations 350.1060e) 350.1210 350.1220j) 350.1230b)7) 350.1230d)1) 350.1230d)2) 350.3240a Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or	Z9999	Attachment A Statement of Licensure Violations	

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Z9999	Continued From page 1 more within a period of 30 days. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: 1a) Based on observation, interview, and record review the facility failed to ensure their policy on Abuse, Neglect, & Mistreatment and Behavioral Supports were followed for 1 of 3 individuals, inside sample (R1) who was physically restrained to administer eye drops following eye surgery on 07/28/15. This failure resulted in injuries to R1 when staff implemented non-authorized restraint while administering eye drop medications. 1b) Based on interview and record review, the facility failed to have evidence that a thorough investigation was conducted for 1 of 3 individuals inside sample (R1), who had unknown injuries	Z9999		

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Z9999	Continued From page 2 including red areas, scratches, and bruising. Findings Include: 1a) The 02/18/15 'Person Centered Plan' (PCP), identifies R1 as an individual who function in the Severe range of Individuals with Intellectual Disabilities (IID). Additional diagnoses include: Bipolar Disorder; Stereotypic Movement Disorder; and Attention-Deficit Hyperactive Disorder. The PCP documents R1's maladaptive behaviors as: Physical aggression (pushing, hitting, and swatting both staff and peers); inappropriate emotional outbursts, and Self Injurious Behaviors (SIB). The 08/13/15 facility 'Statement for Injury of Unknown Origin' for R1, and signed by E4, Licensed Practical Nurse (LPN) documents: 2. Did the injured person have any type of accident or incident that could have resulted in this injury (,) a fall, etc? ... "R1 is on eye drops (,) hands have to be held to try to administer drops (and) hand placed on shoulder to steady R1 (,) also R1 is very hyperactive trying to get out the doors of facility." ... 5. Attempt to date the injury: Does the area look fresh? Is there fresh blood or has a scab formed? ... If the injury is a bruise, what color is it (Yellow, Green, Purple)? ... "2 red marks to inner L (left) wrist approx (approximate) 1 cm (centimeter) + (and) 2 cm 1 purplish blue bruise approx 3 cm; 2 red scratch marks no open area noted 1 is 3 cm and 2nd is 7 cm." ... 6. Note the size and location of the injury? ... "(1.) red mark inner L wrist approx 1 cm; (2.) red mark inner L wrist approx 2 cm; (3.) bruise to L inner wrist approx 3 cm; (4.) red scratch mark to upper	Z9999		

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Z9999	Continued From page 3	Z9999		

back R (right) shoulder area approx 3 cm length; (5.) red scratch mark to upper back R shoulder area approx 7 cm in length."

The facility Nursing Notes have no entries documented for R1 since 07/15/15.

On 08/21/15 at 4:50 PM in the facility medication room E5, Authorized Direct Staff Person, (ADSP), was observed administering eye drops to R1 while E3, ADSP, restrained R1 by holding both R1's hands on R1's thighs.

On 08/21/15 at 3:56 PM; E3, Authorized Direct Staff Person (ADSP) was interviewed. E3 confirmed that E3 has administered eye drops to R1. E3 stated R1 would have to have both hands held by another employee. E3 denied being trained to hold R1's hands for medication administration.

On 08/21/15 at 3:36 PM E5, ADSP was interviewed. E5 confirmed that E5 has administered eye drops to R1 and that R1 would have to have both hands restricted by another employee. E5 denied being trained to hold R1's hands for medication administration.

On 08/21/15 at 3:22 PM E6, ADSP was interviewed. E6 confirmed that E6 has administered eye drops to R1 and that R1 would have to have both hands held on R1's thighs by another employee. E6 denied being trained to hold R1's hands for medication administration.

On 08/21/15 at 3:02 PM E7, ADSP was interviewed. E7 confirmed that E7 has administered eye drops to R1 and that R1 would always have to have both hands held by another employee. E7 denied being trained to hold R1's

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Z9999	Continued From page 4 hands for medication administration. On 08/21/15 at 4:10 PM E2, Qualified Intellectual Disabilities Professional, (QIDP) was interviewed. E2 confirmed that: 1) The facility had not received R1's guardian's approval for the physical hold of R1 during eye drops administration four time daily since 07/28/15. 2) The facility had not secured a physician's order for R1's restraint prior to implementing physical holds on R1 during eye drops administration four times daily since 07/28/15. 3) The facility had not updated R1's PCP to include R1s maladaptive behavior during eye drops administration four times daily since 07/28/15. 4) The facility had not developed a behavior program for R1's behavior prior to implementing physical holds on R1 during eye drops administration four times daily since 07/28/15. 5) The facility's Specially Constituted Committee had not been informed of nor approved to the physical hold of R1 during eye drops administration four times daily since 07/28/15. 6) Direct care staff were not instructed nor trained in a program to use least restrictive measures prior to implementing a physical hold on R1 during eye drops administration four times daily since 07/28/15. 7) The facility failed to obtain data regarding R1's physical restraints during eye drop medication administration for review by the facility's Specially Constituted Committee. The facility Policy and procedures document: "3.000 Definitions ... "Abuse - The ill-treatment, violation... and/or otherwise disregard of an individual, whether purposeful, or due to carelessness...with the	Z9999		

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Z9999	Continued From page 5 intent of inflecting any harm to an individual ... Mistreatment - Any act of failure to act which results in an individual being exploited or subject to humiliation, degradation, or unnecessary fear. Neglect - The term "neglect" is defined ... (A) the failure of a caregiver or fiduciary to provide the the goods or services that are necessary to maintain the health or safety... (B) self-neglect... as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The facility Procedure titled: '6.101 Behavior Support Philosophy Procedure' documents: "4. The Behavior Support Committee and the Human Rights Committee shall address and approve al Behavior Support Plans and/or Behavior Guidelines, dated 07/01/14." The facility procedure titled: '6.102 Behavior Support System Overview Procedure' documents: "14. The QDDP (Qualified Intellectual Disabilities Professional) shall ensure that procedures defined as restrictive shall be subject to review by a Human Rights Committee." 1b) The facility work schedule, from 08/09/15 to date of injury 08/12/15, documents that 14 employees had been scheduled to work. The facility was unable to reproduce evidence that E5, Direct Care Staff (DSP); E6 (DSP); E7 (DSP); E8, Cook; E9 (DSP); E10 (DSP); E11 (DSP); E12 (DSP), or E13 (DSP) were interviewed regarding the injuries of unknown origin to R1 on 08/12/15. On 08/21/15 at 12:55 PM E2, Qualified Intellectual Disabilities Professional (QIDP) was interviewed. E2 confirmed that she did not obtain	Z9999		

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Z9999	Continued From page 6 all the employee statements from the investigation of R1's injuries of unknown origin. (B) 2 of 2) Licensure Violations 350.1060e) 350.1210 350.1230b)7) 350.1230d)1) 350.1230d)2) 350.3240a Section 350.1060 Training and Habilitation Services e) An appropriate, effective and individualized program that manages residents' behaviors shall be developed and implemented for residents with aggressive or self-abusive behavior. Adequate, properly trained and supervised staff shall be available to administer these programs. Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 7) Modification of the resident care plan, in terms of the resident's daily needs, as needed. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a	Z9999		

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Z9999	Continued From page 7 resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure the use of less intrusive techniques were employed prior to employing restrictive techniques for 1 of 3 individuals inside the sample (R1), who was being physically restrained to administer eye drops medication four times a day since 07/28/15. Findings Include: On 08/21/15 at 4:50 PM in the facility medication room E5, Authorized Direct Staff Person, (ADSP), was observed administering eye drops to R1 while E3, ADSP, restrained R1 by holding both R1's hands on R1's thighs. No less intrusive or positive techniques were observed to be employed prior to this restraint. On 08/21/15 at 4:10 PM E2, Qualified Intellectual Disabilities Professional, (QIDP) was interviewed. E2 confirmed that facility had not developed programming for R1 utilizing less intrusive techniques prior to employing physical restraint for R1 when receiving her eye drops medications four times daily since 07/28/15 (B)	Z9999		